

Senate Bill (SB) 553
Working Group on the Implementation Planning for the Incorporation of Nursing and Choices for
Independence Waiver Services in the NH Medicaid Care Management Program

Public Working Session

October 4, 2016
10:30 a.m. – 12:00 p.m.
Legislative Office Building, Rooms 210-211
Concord NH

Introductions and Agenda

Deb Scheetz welcomed Working Group members and interested parties. The agenda was reviewed: Camille Dobson of the National Association of States United for Aging and Disabilities (NASUAD) will present on Managed Long-Term Services and Supports (MLTSS) in other states.

MLTSS - The National Landscape

Camille Dobson, Deputy Executive Director, NASUAD

The NASUAD represents state agencies on aging and disabilities. Its mission is to design, improve, and sustain state systems delivering home and community based services and supports for people who are older or have a disability, and their caregivers. NASUAD staff manage federal policy with Congress and the executive branch (CMS), as well as convene the National Home and Community Based Services Conference. NASUAD areas of focus include technical assistance and policy support to state LTSS systems including community integration, health and wellness, consumer access, sustainability, preventing abuse and exploitation, and measuring quality.

Overview of MLTSS: MLTSS is the delivery of long term services and supports (state plan and waiver) through capitated Medicaid managed care plans. Plans typically cover acute care services as well as LTSS. MLTSS programs have increased significantly across the nation since 2010. In 2016, MLTSS programs vary from those that include dual eligibles only; current statewide or regional programs; those in active development; and those under consideration.

Eight states have comprehensive statewide MLTSS programs that include all Medicaid services (acute, behavioral, LTSS) and enroll most populations. Three of these programs include persons with intellectual/developmental disabilities.

Twelve states have at least one separate program for acute care and LTSS, six of which are dual-only programs. The remaining states with MLTSS have programs for limited populations or in limited geographic areas. MI and NC have statewide, county-based capitated program for mental health and I/DD services only. These programs would not be approved today; CA integrated LTSS in only five counties; MA, MN, and WI have more than one program for LTSS populations.

MLTSS programs generally focus on fully integrating benefits. All include HCBC and nursing facility programs. Several include Medicaid primary and acute care services, self-directed services, and/or Medicare primary and acute services.

States use a variety of strategies to coordinate care for dual eligibles. 80-90% of those receiving coordinated care are duals. Several states have dual alignment demonstrations which CMS is allowing

to run indefinitely. Some states are coordinating with Medicare managed care. The question on how to design the care coordination system is the state's - with some states stipulating in the contract that the MCO must use the current case management system (at least for a period time and see what evolves from there, and other states do not use the existing system.

Trends: MLTSS continues to be the biggest trend for states to address accountability, cost efficiency, and better outcomes. Existing programs are expanding either statewide or beyond duals. The inclusion of LTSS services for individuals with intellectual/developmental disabilities is one of the last areas states have attempted to address (IA, KS, TN, TX include all populations). Different populations require different kinds of care coordination. It is very challenging to take on all at once. TN and TX are long standing programs, but only recently added intellectual disabilities.

Focus on quality: Concerns about quality increase under managed care due to fear of service denials. States are developing new and more meaningful outcome measures for MLTSS, though challenging and slow. A variety of outcome measures are in use including NASUAD's National Core Indicators for Aging and Disabilities consumer quality of life survey, CMS' TEFT experience of care survey, and National Quality Forum's HCBS quality measurement project.

States without managed care capacity are looking at partial-risk alternatives (ACOs). Financially strapped states are looking to expand pay-for-performance/value-based purchasing (though a challenge to develop a reporting structure). MA is looking at a LTSS ACO. There is increasing involvement by MCOs in states' Olmstead plans, as well as housing: and employment

Why should NH pursue MLTSS?

Expenditures: LTSS expenditures represent about one third of all Medicaid expenditures. LTSS account for the largest group of Medicaid services that remain in the fee-for-service (FFS) system in which there is very little accountability for outcomes, as well as a fragmented approach to the "whole person." In 2013, total LTSS expenditures were spent on less than 10% of all Medicaid beneficiaries. Since 2012, managed care expenditures have doubled to nearly 15% of all LTSS expenditures.

Accountability: Remains with one single entity, and the integration of acute and long-term care can lead to more person-centered approach to care. Health plans are at risk if they spend too much. States have the opportunity to incentivize or penalize providers. Managed care is a tool in the state's toolbox that the state must wield well. It is unwise to let the plans do what they want in designing the plan for care coordination. The state runs and owns the care coordination program. Tennessee's contract has 15 pages dealing with care coordination alone.

Administrative Simplification: States can contract with a handful of contractors instead of hundreds of individual LTSS providers.

Budget Predictability: A capitated system provides budget predictability. With 10,000 people per day turning 65, the demand for LTSS services will grow substantially.

Shift Care to Community Settings: Most consumers prefer community-based services; and health plans may be able to effectuate transfers from institutions to community more easily.

Why are states pursuing MLTSS? There are opportunities to serve more people in less restrictive settings. In New Hampshire, just under 50% of beneficiaries are served in community settings.

Achievements: In four years, Tennessee significantly increased the number of consumers served in HCBS and increased its LTSS expenditures on HCBS from 19% to over 50%. New York is seeing improved health outcomes by managing consumers' care. NY assesses individual's ADLs when they enter the program and then re-assesses.

Critical Elements of MLTSS include:

1. Strong care coordination structure is at the heart of the MLTSS system. All states have a continuity of care period where current care plans continue unmodified (will be required by 7/1/18). State review of service plan reductions (TN does 100% review of service plans). Detailed contract language for care coordination and care plan development.
2. Network adequacy standards. Cannot assess at the beginning. Must assess network adequacy while in operation by assessing gaps.
3. Provider contracting and training at start-up. Standardize provider contracts, credentialing and authorization forms, claims testing between MCOs and providers.
4. Consumer protections, including consistent communication about changes; multi-modal choice counseling for plan selection (will be required by 7/1/17). Some states are using traditional enrollment brokers (by phone); and post-enrollment consumer assistance.
5. Timely assessments and service delivery: Build in a service verification system. Most states carry over assessment to MCO contracts. Some states have 10 days to do assessment - timeliness from enrollment. Visit verification systems cut down on fraudulent billing.
6. Strong state oversight and accountability mechanisms. Requires state staff experienced in program management, contract monitoring, network adequacy, quality, and rate setting. Contracts must include stringent MCO reporting and liquidated damages for immediate financial consequences (TN has \$1000/day damages). This is a very effective tool to get plans to pay attention to what the state wants. NY and MN have public reporting of MCO performance.

Discussion:

Q: How do states reimburse so that community programs pay a livable wage?

A: Some states' home care workers are unionized and are paid a living wage. In order to fund the program, something else gets cut.

Q: How many states with managed care include HCBS and nursing facilities services?

A: Nursing services are included in all programs.

Q: Does TN have the best ombudsman program?

A: TN has no ombudsman program. Newer programs have ombudsman programs.

Q: It was stated that some consumers are over-served. That is not the case in NH; some are underserved.

A: In some states, there is one entity doing both eligibility and service provision. Therefore, this inherent conflict allows the provider to drive the process. States are eliminating these conflicts.

Q: NH has intermediary agencies (area agencies). What role do those entities play in the MLTSS system in other states?

A: States have moved care management responsibilities to the health plan. Plans have different models - either contract out or delegate.

Q: What trends are other states experiencing with nursing homes?

A: Addressing nursing facility (NF) services is one of the biggest challenges states face. Almost all states set a floor of the fee-for-service rate for 2-3 years. NF occupancy rates have gone down; states want people served in communities if possible. However, if the acuity level for NF is low, many will qualify for home care.

Public Comment

Parent of 27-year old son with down syndrome is very concerned about the role area agencies will play in the new system. The area agency system works very well for her son who has a service coordinator at a moment's notice and a job coach at for his three jobs. She is "petrified" of budget reductions under a different system of care and suggested the state think about how the state incorporates area agencies into MLTSS.

Next Meeting

The next meeting will be held on Tuesday, October 20, 10:30am - 12:00pm at the Legislative Office Building, Rooms 210-211.